

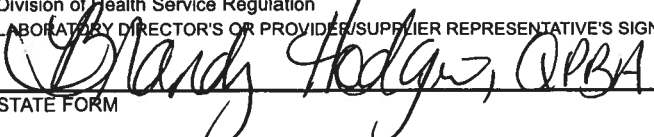
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 000	<p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed on September 11, 2025. The complaints were substantiated (intake #NC00232857 & #NC00232778). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600C. Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000	<p style="text-align: center;">RECEIVED SEP 29 2025 DHSR-MH Licensure Sec</p>	
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the</p>	V 290		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 9/24/25	(X6) DATE
--	------------------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025	
NAME OF PROVIDER OR SUPPLIER LANIER HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 1</p> <p>emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a minimum of one staff member was present at all times when adult clients were on the premises except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision affecting 6 of 6 audited clients (#1, #2, #3, #4, #5 and #6). The findings are:</p> <p>Review on 9/11/25 client #1's record revealed: -Admission date of 8/21/08. -Diagnoses of Mild Intellectual Developmental Disability; Anxiety Disorder; Dysmenorrhea;</p>	V 290	<p>QP will train the New Administrative Assistant to cover in Emergency situations, should the need arise. The Administrative Assistant will be trained by 10/15/25.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 2</p> <p>Anemia; Acne Vulgaris.</p> <p>Review on 9/11/25 of client #2's record revealed: -Admission date of 8/14/08. -Diagnoses of Autistic Disorder; Intellectual Developmental Disability, Mild; Diabetes Mellitus.</p> <p>Review on 9/11/25 of client #3's record revealed: -Admission date of 8/18/08. -Diagnosis of Intellectual Developmental Disability, Mild.</p> <p>Review on 9/11/25 of client #4's record revealed: -Admission date of 1/20/10. -Diagnoses: Moderate Intellectual Disability; Generalized Anxiety Disorder; Tinea Ungums; Hyperlipidemia.</p> <p>Review on 9/11/25 of client #5's record revealed: -Admission date of 1/4/09 -Diagnoses: Major Depressive Disorder, Mild; Intellectual Developmental Disability, Mild.</p> <p>Review on 9/11/25 of client #6's record revealed: -Admission date of 8/15/08 -Diagnoses of Allergic Rhinitis; Arthritis; Diabetes Mellitus; Esophagitis; Hearing Loss; Hyperlipidemia; Hypertension; Peripheral Vascular Disease; Upper GI Bleed.</p> <p>Interview on 9/10/25 with Staff #1 revealed: -Hired 2016. -On 3/29/25 her brother called because her mother was having a nosebleed. -She reported that her mother was very sick. -Her brother called about 10:00 a.m. -She told her brother to take their mother to the emergency room if the bleeding did not stop. -After her brother got to the hospital their mother levels were low.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025	
NAME OF PROVIDER OR SUPPLIER LANIER HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 3</p> <ul style="list-style-type: none"> -Her brother called her back and told her their mother was being admitted. -Her brother reported that it was not looking good and that she needed to get to the hospital. -She did not leave until she administered the medication, clients showered and finished dinner. -She informed the Qualified Professional about 1:30 p.m. that she would need to go to the hospital. -She made sure everything was covered on her end. -The QP was unable get local staff to work. -The QP was too far away from the facility. -The QP was able to get staff #2 to come to the facility. -Staff #2 was a floater and working at another facility 3 hours away. -The QP called a volunteer that was a member of their church to cover until staff #2 arrived. -The clients attended a yearly retreat and church services with the volunteer. -The volunteer knew the clients and their family. -The volunteer arrived about 7:15 p.m. -All the clients were in their rooms. -She left the facility about 8:15 p.m. <p>Interview on 9/11/25 with clients #1, #2, #3, #4, #5 and #6 revealed:</p> <ul style="list-style-type: none"> -They wanted to be interviewed in a group setting instead of individually. -The volunteer was in charge of special ministry at the church. -The volunteer came to the facility to cover for staff #1. -They were emotional about staff #1's mother. -They're taking it day by day. -They were okay with the volunteer coming to the facility. -Staff #1 gave them medication before she left. -Staff #2 came, and the volunteer left. 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 4</p> <p>Interview on 9/10/25 with the Volunteer revealed:</p> <ul style="list-style-type: none"> -The QP called her to sit with the clients until staff #2 arrived. -She was told staff #1 had an emergency. -She went to the facility about 7:30p.m. -She stayed until about 10:30 when staff #2 arrived. -"Everything was fine." -They were like her 2nd family. -They watched television; some sat on the porch and talked. -Clients started to go to bed about 10:00 p.m. -Staff #1 left after she made sure everything was in order. -Staff #1 washed the dishes, gave clients instructions; and gave medication. -Staff #1 gave one of the clients a bath. -Staff #1 left about 8 p.m. or after. -Staff #2 arrived about 10:30 p.m. -She met staff #2, talked for a few minutes and then she left. -Clients did not have any complaints. -She was the client's Sunday school teacher. -Take clients on outings with the group home -She was close to the clients, their family and the organization. -She had known the clients for almost 30 years. -She did not receive training to work with the clients. <p>Interview on 9/10/25 with Staff #2 revealed:</p> <ul style="list-style-type: none"> -She started working for the organization in March 2025. -She worked as needed and as the floater. -Her manager called her about before 7p.m. -She was informed that staff #1 had an emergency and she needed to leave to cover. -She arrived about 10:00 or after; it took her about 3 hours. 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025	
NAME OF PROVIDER OR SUPPLIER LANIER HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The volunteer was at the facility when she arrived. -The clients were getting ready to go to bed. -“Clients tend to go to bed about 10:30 unless they were a watching movie.” -She received training to be familiar with all the clients in organization. -The volunteer did not report any issues. -She did not know how long the volunteer was at the facility. -Clients did not complain about the volunteer being at the facility. <p>Interview on 9/10/25 and 9/11/25 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -She was working at another facility. -She received a call from Staff #1 -She called her supervisor to tell her that staff #1 needed to leave. -She called the alternate staff, but she was out of town. -She called staff #2 who was working at another facility. -Staff #2 was the floater and filled in wherever they had a shortage. -Staff #2 was informed she needed coverage at the facility. -Staff #2 was leaving from a facility 3 hours away. -A call was made to the volunteer who knew the clients and population. -The volunteer was within 5 minutes away. -The volunteer did not have to do anything but supervise the clients. -Staff #1 was still at the facility when the volunteer arrived. -The volunteer was called to cover until staff #2 arrived. -“This was an emergency and staff #1 needed to get to her mother.” -The volunteer stayed until staff #2 arrived. 	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 6 -Staff #2 arrived about 10:30p.m. and the volunteer left. -She sent a group message to the guardians the same day about coverage. -The volunteer was not trained, and the criminal background check and healthcare registry personnel was not conducted. -She would speak with her supervisor to come up with a plan in case of any emergency. -She would look to hire staff that were local. -They had positions posted for a long time. -The administrative assistant's employee file was completed, and she would be used to provide direct care as needed.	V 290		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives,	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 536	<p>Continued From page 7</p> <p>measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <p>(1) knowledge and understanding of the people being served;</p> <p>(2) recognizing and interpreting human behavior;</p> <p>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</p> <p>(4) strategies for building positive relationships with persons with disabilities;</p> <p>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</p> <p>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</p> <p>(7) skills in assessing individual risk for escalating behavior;</p> <p>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</p> <p>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</p> <p>(h) Service providers shall maintain documentation of initial and refresher training for</p>	V 536		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 8</p> <p>at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where they attended; and</p> <p>(C) instructor's name;</p> <p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025	
NAME OF PROVIDER OR SUPPLIER LANIER HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 536	<p>Continued From page 9</p> <p>review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the one of three audited staff (#1) had current training on the use of alternatives to</p>	V 536		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL053-055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LANIER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1428 CARTHAGE STREET SANFORD, NC 27330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 536	<p>Continued From page 10</p> <p>restrictive interventions. The findings are:</p> <p>Review on 9/11/25 of Staff #1's personnel record revealed:</p> <ul style="list-style-type: none"> - Hired date of 8/1/16. - National Crisis Intervention Plus (NCI+) training expired 8/19/25. - There was no evidence of current alternatives to restrictive interventions training. <p>Interview on 9/11/25 the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -She was responsible for staff training. -Staff #1 would be trained this afternoon. <p>"A couple of times training was available but staff #1 was unavailable."</p>	V 536	<p>QP Scheduled staff #1 to receive Alternative Restrictive Intervention training on 9/12/2025. Training was Scheduled and completed. QP will use BCH IDP's Internal training spreadsheet to monitor upcoming training dates of staff.</p>	
-------	---	-------	--	--